CHAIRPERSON JAMES: Doctor Nora, good morning.

DR. NORA: Yes, good morning. I'm delighted to be the fourth speaker or fifth after Doctor Shosky and the other panelists. They covered prevalence, when, how, what were the other lessons due to gambling, so that takes off three pages of my written statement. I would like to focus now on the treatment approaches.

In 1976 the subject of problem gambling was formally addressed by the Commission on the review of the National Policy Toward Gambling. For 22 years the issue of problem gambling was essentially ignored by the Federal Government until 1996 when the National Gambling Impact Study Commission was established. Other than limited funding of treatment services in the Veterans Administration and a few prevalence studies by the National Institute of Mental Health in selected states, the Federal Government has had little involvement in the recognition, treatment, and rehab of pathological gamblers and their families.

Nineteen years after the diagnosis is officially recognized by the American Psychiatric Association, the interest and funding for such treatment services, education, prevention and other programs has not kept pace with the rapid increase in the availability and access to sophisticated forms of gambling. About six years ago I received a call from the Pentagon and someone was very interested in discussing treatment of pathological gamblers. I got so excited about it but it was short-lived. That was the first and the last call I had from a federal level.

In the near future I am more hopeful that this Commission will be able to generate landmark findings and recommendations that will address these problems. I hope it will be in my lifetime and I'm no spring chicken, so there's a sense of urgency in this. (Laughter)

DR. NORA: I also would hope that through all the hearings you'd go beyond economics and taking into consideration human anguish and turmoil and all those indirect costs of gambling disorders. I would like to spend a few minutes on attitudes towards under-age gambling. Despite the research findings and all of the statistics and demographics that has been presented here and in previous hearings, there is still much room for improvement in the areas of education, prevention, diagnosis and treatment.

A lack of attention to this disorder may be attributed to; A; the false notion of the general public, especially parents, to think and assume that rules and regulations pertaining to age 18 or age 21 are already enforced in the casinos. B; perception of gambling as a harmless source of excitement and amusement especially among college students; for example, athletic events, card games, casino events and they even bet on their final grades.

C; the gambling atmosphere and environment offering something for everyone and are particularly attracted to the young because of the fast-paced activities and sensory stimulation. D, inadequate knowledge about problem gambling and its potential for negative impact on the student, the family or community. E; problem gambling not considered as a priority

issue among schools and universities. I come from New Jersey and when I was with Rutgers we tried very hard to include a curriculum for the medical students to include it with the other substance abuse disorders. We could not even squeeze that in so I don't know, I have not made a survey about which universities at all include them in the teaching for physicians, health practitioners, nurses, so on and so forth.

F; legalized gambling seen as a socially acceptable form of recreation. G; lack of funding for continuum of care and services for pathological gamblers. In 1996 the money authorized for problem gambling by state governments is estimated at $13 million. On the other hand, the total allocation for a single drug and alcohol agency in Texas rates about $122 million. Before I go on about under-age gambling, I would like to point out three caveats that we might keep in mind.

Number one, children and adolescents are not small adults. This is also a basic principle in the practice of medicine. They have unique needs and characteristics. They respond to or are influenced by individual social and cultural factors, maybe even more because they are still in that suggestible phase. The adolescent interacts with his/her social setting, availability and access and social approval.

Another factor is that children and adolescents have emotional, psychological and behavioral attributes best described as normal abnormality. And this is why we have to be a little bit more straight. We have to be a little bit more careful in labeling these adolescents and must stick to the criteria for that diagnosis. Right now we have no goal standard, but the

DSM-IV is the criteria. And the last one; some things can wait, our youth cannot.

In the last few days we have seen the -- in the TV segments indicating a task force or a group that is preparing for the year 2020. Well, if you look around at 11-year olds now, they will be 21 and old enough to gamble in the year 2010, so I think it's sort of a heads up that maybe we don't have to wait that long to really get going on these things. Now, in terms of treatment approaches, there are the basic five A's for any measurement or any assessment of basic health services I will mention these five as they relate to problem gambling, especially with the youth.

Number one is availability. Pathological gamblers seek help in different phases of this disorder. The only thing is in my 22 years working with compulsive gamblers and their families, no one has come into me in the winning phase. To insure good continuity of care, there's a core of services that should be available to meet the needs of this population. This should include emergency or crisis intervention services, acute in-patient care, residential and halfway homes, outpatient care and support groups. About 75 percent of gamblers can be treated in an outpatient basis and usually this is in conjunction with Gamblers Anonymous, Gam-Anon for the spouses and Gam-Ateen which is not usually too well organized and does not live very long in most of our communities.

In Las Vegas we have Trimeridian and the VA and Charter who has the officially and formalized gambling programs. In the State of Nevada, there are other facilities; two in Reno,

one in Carson, one is Sparks. Most of the other adolescents who end up to be hospitalized because either of a suicide gesture or perhaps loss of control of behavior or disturbed behavior actually end up in a substance abuse program and I'll tell you a little bit later about why that is not the best solution.

Number two is accessibility. Pathological gamblers who require treatment are admitted to in- patient or outpatient programs using their health insurance benefits or eligibility statutes for care. Most insurance company do not reimburse for a diagnosis of pathological gambling per se but, thank God, we have done with our DIG system (ph). Now we can be reimbursed with a diagnosis of severe depression with or without suicidal features and a recognition of the intensity and acuity of care they need -- that are needed. The problem with this, if we have to hide behind this diagnosis it's very difficult to retrieve cases for studies or for aggregate research when, as I said, the primary diagnosis is recorded as depression or major disorder.

Some programs charge for services based on a sliding scale, according to the patient's capacity to pay. Individuals who have no funds may be cared for as pass-throughs or indigents. I think this is where the Golden Rule comes up. You've all heard about that; the one who holds the gold makes the rules. And the reason why not many facilities are established is because before the patient even comes in, he's already a money loser. And I know that in other states many attempts have been tried to establish a program, but usually they cannot maintain the staffing and all the expenses that go with it.

Number three, appropriateness; in the early 1980's the diagnosis of pathological gambling was new and there were no specialized programs, so we were just encouraging, we were groping and we did not have a framework. We would encourage everyone in the addictive disorders field to take care of them. In this day and age, I recall Doctor Lauren Rogell (ph) from Rexville (ph) and now with Trimerdian, it is no longer clinically ethical for chemical dependency providers to see the similarities with substance abuse and to assume that pathological gambling can be treated in any chemical dependency program.

The primary strength of a gambling specific program is the ability of the gambler to identify with each other. Incidentally, I was asked about how many of our clinicians were certified gambling counselors. From the National Council of Problem Gambling there's about 300. The other one, from New Jersey now called American Certification Board has 218. So in Las Vegas we have about 91 who are either certified or have the clinical equivalent of it in their experience. We are talking about less than 1,000 qualified gambling specific therapists. That is compared to 36,000 for the substance abuse and other addictions.

Number four, accountability; the responsibility of dealing with problem and pathological gamblers with various agencies, that has already been mentioned. This includes if you are especially in Las Vegas almost everyone; gaming industry, mental health and other professionals, health care and insurance industry, researchers, local, state and federal agencies and legal and criminal justice systems. Efforts to support education,

prevention, outreach, help line programs and treatment services are much needed.

Five, acceptability; a positive outcome of -- recognizing pathological gambling in DSM-IV, well, initially in DSM-3, is that it has led to the medicalization of the disorder and the patients and their families are more willing to come in for treatment rather than the situation being sabotaged because of lack of understanding or poor communication.

I have only two minutes and in my statement I have mentioned about the basic elements of the parent treatment programs. We are all like disciples and apostles of Doctor Custer (ph), so the kinds of treatment we keep teaching and we keep going on is the same model. No one that I know of has really -- or maybe there are but I'm not aware, compare this with other possible treatment approaches. Cognitive approaches, we think this is the best because that's what we know but it needs funding, it needs researchers and time and a lot of manpower to do those studies.

In conclusion, I would support everybody else's recommendation. I would just point out that the inclusion of the topic of prevention and treatment of gambling in the health programs of the school. These are already in place with the substance abuse and in Las Vegas we've been trying for four years, we're still trying but maybe the impact of your visit is that it might be accelerated before the millennium begins.

Responsible gaming programs should be developed by the gaming companies as a whole and not just pockets of excellence in certain states. Adequate funding and support of

treatment and care services in each state, especially the young, they don't even -- they're not even earning yet or if they are that's meager enough to have a down payment for a car or for women their clothing.

Number 5, nationwide research must be done even with Doctor Shaffer's sampling, it is a very, very small sampling that is very hard to generalize. I must mention to you that many of us who started in the field about 20 years ago, we don't see them. I'm at the VA, so I am really biased, but I do work also in the community. They just don't come out for treatment. Now, the school is the first line of defense, but if you do not even have trained counselors or teachers and they're not sensitive to the problem, they will not ever get to us either.

Well, I think that that concludes my presentation and, again, I thank you for the opportunity. Oh, I forgot one thing; maybe we can consider a uniform age limit and not just bounce from 18 to 21 because they'll go jumping from state to state anyway. So that might be food for thought.

CHAIRPERSON JAMES: Thank you, Doctor Nora.